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AUTHOR Eisenthal, Sherman
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ABSTRACT

One hundred and fifteen patients coming to a psychiatry walk-in clinic were evaluated for suicidal ideation prior to their intake interview. Sixty percent of the patients had suicidal ideation, 20% to an extreme degree. Recognition of suicidal ideation, based on a content analysis of the clinical chart, was 27% for the entire group and 56% for the extreme group, and was not related to the intensity of symptoms nor to requests for control. (Author)

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Communication of Suicidal Ideation in a Walk-In Clinic*

Sherman Eisenthal, Ph.D.
Dept. of Psychiatry, Massachusetts Genl. Hospital

Problem. Establishing the presence and evaluating the significance of suicidal ideation constitute an especially important task in a crisis setting. It is the general thesis of this study that recognition of suicidal ideation falls far short of its actual presence in the applicant. It is our clinical observation that patients may not state and clinicians may not ask about suicidal ideation. In this study we investigated the relationship between the recognition of suicidal ideation and two sets of independent variables: one, the magnitude and kind of requests the patients have for help, and two, the magnitude of their symptoms and mood as measured by a symptom checklist and mood scale. We believe that both these sets of variables have implications for motivation to communicate about suicidal ideation and the readiness of the clinician to perceive suggestive cues and make inquiries.

The following hypotheses have been formulated regarding recognition of suicidal ideation:

1) Recognition will fall noticeably short of the actual occurrence of suicidal ideation.

2) Recognition will correlate with the subjective strength of the suicidal ideation.

3) Recognition will correlate with patient's motivation to communicate as measured by scores on the Patient Request Form, especially on requests for control.

4) Recognition will correlate with anxiety and depression scores on a symptom checklist and mood scale.

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Subjects. The subjects were 115 randomly selected patients from a pool of 225 patients who came to the Acute Psychiatry Service at the Massachusetts General Hospital between July and December of 1973. The subjects were evenly divided by sex (49% female and 51% male) and ranged in age from the late teens to the early 70's. Most of the patients (85%) were between the ages of 20 and 50. The distribution of social class (using the Hollingshead Two-Factor Index) was Class I and II, 14%, Class III, 34%, Class IV, 37%, and Class V, 14%.

Procedure. Patients coming to the walk-in clinic who were either new or who had not been to the clinic in one month were asked to participate in the study. They were administered a brief face sheet questionnaire, the Hopkins Symptom Checklist, and the Patient Request Form. In the Hopkins Symptom Checklist, we were using the item "thoughts of ending your life" as our measure of suicidal ideation, the response format was from "not at all" to "extremely". The Patient Request Form contains fourteen request categories and 84 items. These categories are Clarification, Ventilation, Control, Confession, Psychological Expertise, Psychodynamic Insight, Reality, Advice, Succorance, Community Triage, Medical, Social Intervention, Administrative Request, and Nothing.

The measurement of the recognition of suicidal ideation was based on a content analysis of the clinical note written in the patient's chart. The note was rated for the presence or absence of suicidal ideation and for degree of risk rated, ranging from not mentioned/not a risk to risk present. Rater reliability was quite high, > 90%.

Results. For the entire sample (N=225) suicidal ideation was distributed as follows: not at all, 41%; a little, 20.4%; moderately, 18.1%; and extremely, 20.4%. The content analysis of the clinical charts was based on a subsample of 115 patients (Table 1). The distribution of suicidal ideation scores was as follows: not at all, 33%; a little, 28.7%; moderately, 18.3%; and extremely, 20%.

Recognition of suicidal ideation was as follows: not at all, 8%; a little, 18.2%; moderately, 9.5%; and extremely, 56.5%. We thus find support for the first hypothesis that recognition will be far short of the actual "rated" occurrence of such ideation. The $r=.33$, $p < .01$. We also found support for the second hypothesis of a relationship between recognition of suicidal ideation and the strength of such ideation.

The rationale that there will be a relationship between requests and communication of suicidal ideation was supported by the correlation between patient requests and the measure of suicidal ideation (Table 2), especially for control, $r=.26$; insight, $r=.22$; and confession, $r=.19$. All three correlations are significant. The hypothesis, however, that recognition would be related to requests for control was not supported. Unexpectedly, we found that recognition was related to the medical requests ($p=.04$). Patients with suicidal ideation who were not recognized tended to have a higher score on the medical request.

Recognition was correlated with depression as hypothesized, but not with anxiety (Table 3). A finer test of the relationship of symptoms to recognition (the communication issue) was made by evaluating only suicidal ideators. They were divided into recognized and not recognized groups and t-tests were run on their symptom and mood scores. We found a trend for identified patients to have higher depression scores (SCL) and lower vigor scores (Mood) than the non-identified patients (Table).

Implications. A significant percentage of patients are not recognized as having suicidal ideation, and it is not clear whether this is due to patients not communicating (or wanting to do so) or due to clinicians not asking. There are a number of possible reasons on both sides. On the patient's part it may involve trust, fear of consequences, misperception -- saying one is depressed = suicidal, testing the relationship, feeling better during the interview. On the clinician's side, it may involve the absence of salient cues, e.g., depression

and lack of vigor and the assumption that a leading question was asked, fear of offending the patient. It remains for future study to resolve these questions. I would suggest that direct inquiry will yield, unexpectedly, a number of patients who are ideating. It may be useful for clinicians to ask themselves if they systematically inquire about suicidal ideation and, if not, why not.

Table 1

Percentage of Suicidal Ideation on SCL Item

Suicidal Ideation	Total Sample N = 225	Subsample N = 115
Not at all	41.0	33.0
A little	20.4	28.7
Quite a bit	18.1	18.3
Extremely	20.4	20.0
	99.9	100.0

Table 2

Correlations of PRF Scales with Suicide Measures

PRF Scales	SCL Suicide Ideation (N=115)	Suicide Recognition (N=115)
Clarification	0.149	-0.072
Ventilation	0.139	-0.122
Control	0.257**	0.022
Confession	0.185*	0.078
Expertise	0.014	-0.143
Insight	0.224*	0.033
Reality Contact	0.130	0.079
Advice	0.131	-0.087
Succorance	0.168	0.096
Triage	0.002	-0.199*
Medical	-0.068	-0.214*
Social Intervention	0.138	-0.033
Administrative	-0.038	-0.113
Nothing	-0.059	0.042
Factor 1 (Affective Dependent)	0.189*	-0.050
Factor 2 (Cognitive)	0.128	-0.130
Factor 3 (Action)	0.073	-0.076
Total	0.175	-0.101

*Significant at the .05 level
**Significant at the .01 level
***Significant at the .001 level

Table 3

Correlations of POMS Scales with Suicide Measures

SCL Scales	SCL Suicide Ideation	Suicide Recognition
	(N=115)	(N=115)
Anxiety	0.347***	0.183
Somatic	0.272**	0.167
Depression	0.528***	0.280**
Anger	0.328***	0.174
Obsessive	0.334***	0.239**
Psychotic	0.387***	0.195*
Sex	0.364***	0.204*
POMS Scales	(N=113)	(N=113)
Tension	0.249**	0.106
Depression	0.509***	0.252**
Anger	0.244**	0.150
Vigor	-0.287**	-0.244**
Fatigue	0.293**	0.080
Confusion	0.409***	0.226*

*Significant at the .05 level.
**Significant at the .01 level.
***Significant at the .001 level.

Table 4

t-Tests

Identified vs. Unidentified Suicidal Patients:

SCL and POMS Scores

	Identified	Unidentified		
SCL Category	Mean	Mean	t	p
Anxiety	39.58	37.42	-	NS
Somatic	28.33	26.29	-	NS
Depression	36.42	30.87	1.67	.10
Anger	9.42	7.10	-	NS
Obsessive	11.33	10.26	-	NS
Psychotic	19.42	17.35	-	NS
Sex	6.08	5.19	-	NS
POMS Category				
Tension	25.17	26.38	-	NS
Depression	45.33	40.31	-	NS
Anger	22.67	19.07	-	NS
Vigor	5.25	8.76	-1.67	10
Fatigue	16.67	19.52	-	NS
Confusion	19.50	17.69	-	NS